COUNTY PHYSICAL THERAPY, LLC

For County Physical Therapy use only
CPT Clinic:
Registration Employee:
Date of Initial Evaluation:

Patient Name: **Date of Birth:**

_____ Consent to Treat
I hereby consent for County Physical Therapy, LLC to provide therapy and rehabilitation services that they consider appropriate in my treatment. Upon each visit to County Physical Therapy, I will be required to sign in to verify attendance and treatment, and such signature will be testament for the billing process.

_____ Financial Responsibility and Assignment
I understand and agree that I am ultimately responsible for payment of services rendered.

If insurance or other third-party payer information is provided, County Physical Therapy will bill that payer as a courtesy and convenience. I understand that I am responsible for ensuring coverage and authorization for treatment, including referrals, limits of coverage, and in-network status. I also understand that I am still responsible for deductibles, co-insurances, co-pays, and any services that are not covered by this payer, and that payment is due at each treatment.

If a third-party payer denies coverage for any reason, including, but not limited to, non-covered or lapsed insurance, contested workers compensation claims, or unsuccessfully pursued liability, I understand that I am still responsible for payment in full.

For services that are covered, I authorize payment from my insurance or other third-party payer directly to County Physical Therapy. If I, or my agent or other representative, receive payment from any third-party payer for services delivered by County Physical Therapy, I will transfer, assign, and/or make prompt and complete payment to County Physical Therapy.

_____ Additional Medicare Waiver (if applicable): Medicare regulations prohibit simultaneous Home Health Service and Outpatient Physical/Occupational Therapy. I certify that I am not currently receiving any Home Health Services, and I will notify County Physical Therapy if I intend to begin receiving Home Health Services during my treatment. I understand and agree that in the event that Medicare denies payment to County Physical Therapy as a result of simultaneous Home Health Services, I am fully responsible for payment for these services to County Physical Therapy.

_____ Notice of Privacy Practices
I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for County Physical Therapy, LLC.

In addition, I hereby consent to the use and disclosure of my Protected Health Information for the purposes of treatment, billing, and health care operations.

Additional releases of Protected Health Information will require an additional signed authorization.

_____ Authorization to release Protected Health Information <u>to</u> County Physical Therapy: I authorize the release of my Protected Health Information **<u>to</u>** County Physical Therapy for the purposes of evaluation, treatment, and billing.

_____ Cancellation/No Show Policy
I understand that appropriate notice (usually 24 hours) is required to cancel or reschedule an appointment. For missed appointments that were not properly cancelled or rescheduled, I may be subject to a $20.00 fee. This fee can not be billed to insurance. Repeated incidences may lead to discharge from treatment.

By my initials above and signature below, I acknowledge that I have read, understand, and agree to the policies of County Physical Therapy, LLC. in receiving rehabilitation treatment.

Patient Signature: _____ Date: _____

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____ Date: _____